Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		FCL072011	B. WING		03/0	3/2015	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 117 GREGORY'S LANE						
			RD, NC 2794	4		T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
	Report by Rick Ben	ton					
	Survey on March 3, 11:30am and conclurecords indicate the August 1, 1968 as a On April 1, 1984 the increase from five t (able to evacuate a physical or verbal a emergency). Based requiring the home the following: 1984 Minimum Standard: applicable portions Care Homes", and Carolina State Build Section 409.1(g).	a Section conducted a Biennial 2015. The survey began at uded at 12:45pm. DHSR home was first licensed on a 5 bed Family Care Home. The home was granted a capacity of six ambulatory Residents and respond without any saistance during a fire or other don this information we are to maintain compliance with "Family Care Homes and Regulations", the of the 2005 "Rules for Family the 1978 Edition of the North ding Code (Revision 5) -					
C 174	Building Equipment	Maintained Safe, Operating	C 174				
	EQUIPMENT (a) The building ar mechanical, and plucare home shall be operating condition (j) This Rule shall family care homes. This Rule is not mean to the condition of the condition of the care homes.	and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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		FCL072011	B. WING		03/0	3/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
WOODVILLE MANOR 117 GREGORY'S LANE HERTFORD, NC 27944							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
C 174	Continued From pa	ge 1	C 174				
	technician to install	r. Contact a qualified a transitional ramp. Provide ur office when completed.					
	living room, the win cracked pane. Cor	between the bathroom and dow on the right has a stact a qualified technician to pane. Provide documentation completed.					
	living room, the mo peeling paint. Cont scrap and repaint the	between the bathroom and lding above the windows have act a qualified technician to he area. Provide ur office when completed.					
	facility, there is a la appeared from a pr qualified technician	droom on the left side of the rge ceiling stain that has evious roof leak. Contact a to treat the stain with an eker. Provide documentation to appleted.					
	the window will not opened. Contact a the necessary repa	beside the office/staff room, stay in the up position when qualified technician to make irs to the window. Provide ur office when completed.					
	and must be replace technician to replace	chind the dryer is damaged ed. Contact a qualified the the paneling. Provide ur office when completed.					
	is severely damage Contact a qualified	the rear bedroom's bathroom d and must be replaced. technician to replace the documentation to our office					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED			
	FCL072011	B. WING		03/0	3/2015			
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
WOODVILLE MANOR		ORY'S LAN RD, NC 2794						
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
small ceiling stain the previous roof leak. It to treat the stain with Provide documentate completed. 9) The rear deck state be repaired. Contact make the necessary documentation to out 10) The rear ramp to Contact a qualified to	om's bathroom, there is a pat has appeared from a Contact a qualified technician in an approved stain blocker. Sion to our office when the state a qualified technician to a repairs to the steps. Provide ar office when completed. The shade the documentation to our office when the state of the steps in the steps. The shade of the steps is a state of the steps. The shade of the steps is a state of the steps in the steps	C 174						

Division of Health Service Regulation STATE FORM